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Social Support: Coping and Stress Related Growth
among Adults with Mental Illness

by

Tara J. Reopelle, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of
Master of Social Work

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Stephanie Faber, MSW, LICSW
Susanna Bertelsen, MS, RN, PHN

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The purpose of this research study was to understand the relationship with social support and coping along with stress related growth in adults with mental illness. The research study sample involved six adults with a serious and persistent mental illness that were part of an assisted living and intentional community program. The methodology used in this research study was qualitative and semi-structured interviews. Findings included demographic information as to the age, education, and religious and/or spiritual status of the study participants. Data content analysis of the semi-structured interviews revealed themes of social support, learning from others, coping with feelings and stress, managing conflict and assertiveness, and people reaction's to mental illness. Research participants did perceive receiving social support and being able to cope as helpful. Stress related growth was concluded based on the responses from research participants in semi-structured interviews and the use of the general meaning making model.

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Table of Contents

Introduction and Purpose Statement	6
Literature Review and Research Question	9
Conceptual Framework	16
Methodology	
Research Design	19
Sample	19
Protection of Human Subjects	19
Recruitment Process	20
Confidentiality/Anonymity	20
Protocol for Informed Consent	21
Data Collection	22
Data Analysis Plan	22
Findings	24
References	19
Discussion	34
Implications	39
Strengths and Limitations	40
References	42
Appendices	45
A. General Meaning Making Model	

- B. Agency Letter of Acceptance
- C. Agency Flyer
- D. Research Participants' Consent
- E. Interview Schedule
- F. Themes
- G. Thematic Relationships

Social Support: Coping and Stress Related Growth Among Adults with Mental Illness

According to the World Health Organization in 2001, approximately 25% of the world's residents were impacted with a mental illness at one time in their lives (as cited in Walton-Moss, Gerson, & Rose, 2005). Furthermore, the National Institute of Mental Health reported in 2001 that among all diseases, mental illness was the most prevalent with the sole exception of heart disease (as cited in Walton-Moss, et al., 2005). The significance of the number of individuals impacted by mental illness illustrates the importance of properly addressing this health issue. The most readily and efficacious methods used in addressing mental illness focuses on treating symptoms and helping individuals with mental illness improve daily functioning. However, the aspect of social support may be a component that has been overlooked in the care and treatment of individuals with mental illness.

The concept of social support is defined as the interactions and resources given by individuals to help other individuals in coping with problems (Wills & Filer-Fegan, 2005). Social support in of itself is a coping method, however, in this research study the interactions that are experienced in helping to cope with mental illness will be the focus. The word "individuals" used to define social support in this research is broad and therefore can include spouses, significant others, GLBT community, families, friends, neighbors, professionals, and others. Social support received by individuals with mental illness may not only be helpful with coping with mental illness, but perhaps have far more reaching implications. One implication may be that social support is associated with stress related growth among adults with mental illness (Chiba, Kawakami, &

Miyamoto, 2011). Stress related growth is defined as actual changes that people have undergone in connection to an event that was traumatic or stressful (Park, 2009). Stress related growth has also been identified as benefit finding, adversarial growth, and growth (Park, 2009). However, for the purpose of uniformity and this research study, the term stress related growth will be used. The idea that social support may be an important component for individuals coping with mental illness highlights the need to utilize more resources to understand how social support impacts individuals in coping with their mental illness. Further, an understanding between coping and stress related growth would be beneficial to gain more of an understanding of how social support may influence individuals to experience stress related growth. However, there has only been a small amount of research done to understand this relationship (Chiba, et al., 2011).

The purpose of this research study is to seek best practice strategies when integrating social support with an emphasis on social interactions in the care of adults with mental illness. In other words, this research seeks to find what happens when social support occurs and individuals with mental illness learn coping methods from those social interactions and how this ability to cope may influence the experience of stress related growth. Further, according to the research literature, other factors besides learning to cope from social interactions may implicate individuals' ability to experience stress related growth. These factors are education level, age, religiosity and/or spirituality and will be taken in to consideration as to how they factor in with the ability to experience stress related growth.

In summary, this research study seeks to: 1) learn how social support influences coping among adults with mental illness and 2) how this ability to cope as a result of

social support influences the experience of stress related growth among adults with mental illness. Social work should be concerned about the social support adults with mental illness receive because not only does it help them to cope with their illness but in coping with other stressors in their lives as well. Also, the premise that social support can implicate stress related growth would be useful to individuals with mental illness to realize personal strengths, set goals, and assess their quality of life which would be helpful in experiencing lives that are meaningful to this population.

A review of the literature focused on studies involving social support and illness, coping with illness, stress related growth and illness, and other predictors of stress related growth. Literature review on social support and illness revealed families with a mentally ill family member sought support and that emotional closeness was indicative of a family's ability to cope. Further, individuals with mental illness perceive a lack of social support in health care settings except during hospitalizations (Crowe & Lyness, 2014; Danoff-Burg & Revenson, 2005; Doornbos, 1996; Kilbourne, McCarthy, Post, Welsh & Blow, 2007; Huang, Sousa, Tsai, & Hwang, 2007). Literature review on coping with illness involved families and how their coping such as talking about illness and thinking about the illness was helpful. Also, the ability to find benefits surrounding an illness and experiencing change was discussed (Crowe & Lyness, 2014; Doornbos, 1996; Katz, Flasher, Cacciapaglia, & Nelson, 2001; Kinsinger, Penedo, Antoni, Dahn, Lechner, & Schneiderman, 2006; Roberts, Lepore, & Helgeson, 2006; Schulz and Mohamed, 2004; Thornton and Perez; 2006). Literature review on stress related growth and illness involved how thinking, appraisal, problem solving, emotional support, and looking for meaning are related to the experience of stress related growth (Thornton & Perez, 2006;

Widows, Jacobsen, Booth-Jones, & Fields, 2005). The literature on other predictors of stress related growth included age, education, and religiosity and/or spirituality may impact an individual's ability to experience stress related growth (Calhoun, Caun, Tedeschi, & McMillan, 2000; Cordova, Cunningham, Carlson, & Andrykowski, 2001; Costa & Pakenham, 2012; Fortune, Richards, Griffiths, & Main, 2005; Katz, Flasher, Cacciapaglia, & Nelson, 2001; Kinsinger, Penedo, Antoni, Daun, Lecher, & Schneiderman, 2006; Linley & Joseph, 2004; Thornton & Perez, 2006; Widows, et al, 2005).

Social Support and Illness

The literature on social support and mental illness involved families and how they managed having a family member with a mental illness. Doornbos (1996) did a descriptive study comparing families with a mentally ill member to families without a mentally ill member. The themes identified in this study were family coping, family health, and family stressors (Doornbos, 1996). Doornbos (1996) found that families with a mentally ill member used the behavioral approach of looking for social support more so than families without a mentally ill family member. Doornbos's findings suggest that families with a mentally ill member that seek social support may lack the necessary skills to manage caring for a family member with mental illness. Families could then benefit from learning approaches to provide social support to family members with mental illness.

A national mental health organization that has undertaken the educating of families for family members with mental illness is the National Alliance of Mental Illness (NAMI). The educating of families is designed to give the support and information they

need. Crowe and Lyness (2014) did a study surveying members from the National Alliance of Mental Illness (NAMI) regarding family relationships with a seriously mentally ill family member. Some variables of interest that were evaluated were coping, family functioning, emotional closeness, and distress in the family (Crowe & Lyness, 2014). The researchers found that a majority of the study participants indicated they were either very emotionally close at 50.6% or emotionally close at 23% to the family member with a mental illness (Crowe & Lyness, 2014). In addition, they found that emotional closeness was affirmatively correlated with family coping (Crowe & Lyness, 2014). Crowe and Lyness's research suggests that the more emotionally close families are towards a family member with mental illness, the more they are able to cope. Families that learn coping skills to relate to a mentally ill family member could then become more emotionally close. The idea of the importance of improving coping skills to improve emotional closeness with mentally ill family members is supported in Danoff-Burg and Revenson's (2005) research involving a longitudinal study on rheumatoid arthritis patients and their social relationships. The researchers found that among all the interpersonal benefits that were described by the patients, 40.3% consisted of statements of enjoyment from the support they received from their loved ones (Danoff-Burg & Revenson, 2005). Danoff-Burg and Revenson's research suggests that when ill individuals actively receive support from their loved ones that it is beneficial to their well-being.

The literature review also included studies on where there is a lack of social support for individuals with mental illness. Kilbourne, McCarthy, Post, Welsh and Blow (2007) researched patients in the Veterans Affairs health system comparing the

instrumental, emotional, and structural support that patients with a serious mental illness and without a serious mental illness had. A finding in their study indicated that patients that had a serious mental illness were one and a half to two times more likely than patients without a mental illness to report inadequate social support (Kilbourne, McCarthy, Post, Welsh & Blow, 2007). The reported lack of social support in the aforementioned study suggests a very real need for social support for individuals with mental illness that may go beyond that of the Veterans Affairs health system. The lack of social support identified in a major health care system is supported by research involving patients in a mental health hospital which found social support was affirmatively related to the amount of hospitalizations for the patients (Huang, Sousa, Tsai, and Hwang, 2007). The researchers did qualify that the affirmative relationship between social support and hospitalizations may have been due to the study participants receiving more social support from healthcare workers during their hospitalizations (Huang, Sousa, Tsai, & Hwang, 2007). Nevertheless, the researchers suggest that individuals with mental illness perceive social support to be beneficial in the care they receive.

Coping with Illness

Studies in the literature review on coping with illness involved how families and ill individuals used different coping strategies. Doornbos's (1996) research which was described earlier found that families with a mentally ill family member used the coping strategies of reframing and passive appraisal more often than families that did not have a mentally ill family member. Also, research on families with a mentally ill family member that involved coping strategies also supported the idea that social support predicted reframing (Crowe & Lyness, 2014). Research on the benefits of talking about

one's illness is supported where social support involving indirect and social comparisons was revealed to be the strongest forecaster of changes after undergoing a traumatic surgery for patients with a diagnosis of cancer (Schulz & Mohamed, 2004). However, the researchers caution that the patients' adjustment to a diagnosis of cancer may have occurred before their surgeries therefore were already receiving social support (Schulz & Mohamed, 2004). Although individuals that are diagnosed with an illness, including mental illness, may or may not have adequate social support before their diagnosis, study findings in the research literature suggest that using different methods to cope is helpful.

Individuals that use coping strategies as a part of relating to family about their mental illness may also benefit on a personal level. Robert and colleagues' (2006) research on patients that were treated for prostate cancer found that although patients experienced quick recovery and affirmative change, there were findings that social support may improve mental functioning by facilitating cognitive processing. Patients that did not have a lot of social support were less apt to think about their situation (Roberts, Lepore, & Helgeson, 2006). Nevertheless, the findings in this research suggest that thinking about one's illness may help with coping. Also, despite the fact that Roberts and colleagues' research involved study participants with prostate cancer, coping with physical illness such as prostate cancer does have a mind and body connection that cannot be disregarded which was suggested by the researchers. Whether illness impacts the mind or body, coping is equally important.

Research on individuals that use coping strategies due to illness suggests an ability to change. Thornton and Perez's (2006) study found that prostate cancer survivors that dealt with a stressor formulated a positive perspective which may have developed

actual positive changes or at a minimum provided the observation that changes had happened. Kinsinger and colleagues' (2006) research that involved stress related growth in men treated for prostate cancer revealed important affirmative relationships to that of active coping approaches and finding benefits. The ability to perceive benefits to illness was suggested in research involving patients with cancer and lupus that indicated benefits such as compassion for others, a stronger appreciation for life, and an increased ability to express feelings out in the open (Katz, Flasher, Cacciapaglia, & Nelson, 2001). Costa and Pakenham's (2011) research on patients with thyroid cancer and psychological adjustment found that stress related growth was related to increased positive affect and positive changes in lifestyle. Findings in the research literature regarding ill individuals perceiving benefits despite their illnesses suggest stress related growth.

Stress Related Growth & Illness

The literature included research that involved stressful events and coping. Calhoun and colleagues (2000) found that when individuals ruminate over a traumatic event soon after the event, they were more apt to experience stress related growth (2000). They also found a correlation that when individuals process a traumatic event with intention and its possible meaning, they were more apt to share the experience of stress related growth (Calhoun, et. al, 2000). Widows and colleagues (2005) research had a significant finding that patients who received a bone marrow transplant that did approach coping such as positive appraisal and problem solving demonstrated stress related growth. Another finding in their research involved some support for the relationship between coping and appraising with stress related growth (Widows, Jacobsen, Booth-Jones, & Fields, 2005). Thornton and Perez's (2006) research findings involving prostate

cancer survivors and their partners revealed that using emotional support and positive reframing showed a strong association with stress related growth. Cordova (2001) did research involving stress related growth comparing a group of female breast cancer survivors to a group of females that were relatively healthy. The group of female breast cancer survivors revealed greater stress related growth compared to that of the relatively healthy group of females (Cordova, 2001). Findings in the research literature are supportive of the idea that individuals with illness such as cancer are able to cope and experience stress related growth.

Although there has been a lot of research with physical illness and stress related growth, there has not been a lot of research with mental illness and stress related growth. This could be due to the fact that when individuals are diagnosed with a physical illness, there are a number of diagnostic tests that can confirm a tangible existence of individuals' physical illnesses. The tangible existence of a physical illness then encourages social support. However, the diagnosis of a mental illness is done using a number of diagnostic tools as well, but the existence of mental illness is ambiguous and the need for social support not understood. Roe and Chopra's (2003) one year study performing bimonthly assessments of 43 individuals with mental illness emphasizes the need for research on mental illness and stress related growth. Findings in their research suggested that for some of the research participants coping with a mental illness contributed to stress related growth although mental illness had other unfavorable outcomes (Roe & Chopra, 2003). However, Roe's and Chopra's research does establish an opening for continued research on individuals with mental illness and stress related growth which is a focus in this current research study.

Overall, general consensus on how stress related growth is experienced is supported by research from Linley and Joseph. The researchers reviewed the literature regarding affirmative change following trauma and indicated that stress related growth was affirmatively related to acceptance, focused coping, and affirmative reinterpretation (Linley & Joseph, 2004). Additionally, focused coping and social support that had an emotional component were also affirmatively related to stress related growth (Linley & Joseph, 2004). Surprisingly, social support was commonly not related to stress related growth (Linley & Joseph, 2004). However, a clear relationship between social support and stress related growth is not available because the assessment of improved relationships which is used as a plausible stress related growth outcome is likely to be confounded with other factors on social support (Linley & Joseph, 2004).

Other Predictors of Stress Related Growth

The literature also included research on education, age, and religiosity and/or spirituality that can impact an individual's ability to experience stress related growth. Regarding education, Widows and colleagues (2005) studied a sample of patients that had received bone marrow transplants due to cancer and found that patients with a lower education level indicated better stress related growth. However, Katz and colleagues (2001) found that education level was not related to stress related growth. Furthermore, patients that only had a high school diploma were more discouraged than patients that had some college (Katz et al., 2001). In addition, Kinsinger and colleagues (2006) found in their study that stress related growth did not relate to education level. Research on education level being a factor for stress related growth has had mixed results and there is no clear relationship between the two.

The factor on age and stress related growth involved research done by Fortune and colleagues (2005) found patients being diagnosed and treated for psoriasis at a younger age experienced stress related growth. Cordova and colleagues' (2001) controlled study comparing female post breast cancer patients with a group of healthy females found a similar connection to that of age and stress related growth. Widows and colleagues (2005) study regarding a sample of patients that had received bone marrow transplants due to cancer went in a slightly different direction finding that younger age was related to better stress related growth but that the amount of stress related growth measured might be lower than what was in the general population. Thornton and Perez (2006) determined in their sample that among the older participants that age was not related to stress related growth and that even including age in their analyses did not impact the results of the study. Linley and Joseph's (2004) review of thirty-nine empirical studies on stress related growth after adversity and trauma found that on a longitudinal basis there was no significance in age regarding stress related growth. Kinsinger and colleagues (2006) concurred in their study that stress related growth did not relate to age although their study sample was small involving men that were treated for localized prostate cancer and were older than 55. Research on age and stress related growth has had mixed results and there is no clear relationship between the two.

The factor on religiosity and/or spirituality may have to do with stress related growth. Calhoun and colleagues (2000) found that soon after an event, the more reflection that is done and the bigger the openness to spiritual change resulted in more stress related growth. In addition, the amount of spiritual involvement did not single handedly forecast stress related growth; however, the willingness to experience spiritual

change was single handedly predictive of the level of stress related growth reported (Calhoun, et al., 2000). Costa and Pakenham (2012) found that spiritual well being was greatly affiliated with stress related growth and that it is striking. Research on religiosity and/or spirituality does indicate a relationship with stress related growth.

A review of the literature serves as a basis for what this research study hopes to clarify on what the best strategies are when integrating social support, coping methods, and stress related growth among adults with mental illness. This research study hopes to support that adult with mental illness that do perceive social support from other people, that through these interactions from other people, have learned ways to cope. This study also seeks to support that through learned coping from other people that individuals with mental illness experience stress related growth. In addition, it would be interesting to find support for other factors such as education level, age, and religiosity and/or spirituality as being influential in experiencing stress related growth.

Conceptual Framework

The conceptual framework being utilized in this research study is the general meaning making model which is involved in most theories of actual stress related growth (Park, 2009) (Appendix A) The general meaning making model starts with a trauma or event that is perceived to be a stressor by an individual (Park, 2009). This starting point is what most theories of stress related growth start with and involves differentiating between positive changes that may come from normative development rather than positive changes that come from a stressor (Park, 2009). The next consideration for the general meaning model is an individual's global meaning before a trauma or event (Park, 2009). Global meaning is defined as an individual's perspectives on the possibility of

positive change such as their behavior matching their goals and values, spiritual or religious life, relationships with people, view on life, and coping ability (Park, 2009).

The next step in the general meaning making model is that due to the trauma or event, an individual's global values and beliefs become inconsistent with the perceived meaning of the trauma or event (Park, 2009). The end result of these inconsistencies can bring about emotional pain and discomfort and therefore motivate individuals to reconcile the inconsistencies between their perspective of the trauma or event and their global meaning (Park, 2009). Although the emotional pain and discomfort over the trauma or event may pass, the notion that the trauma or event could happen again can interrupt an individual's sense of control or belief of being untouchable (Park, 2009). This is when meaning making can be helpful in reconciling the trauma or event to their global meaning. Meaning making is when individuals participate in emotional and cognitive methods to bring together the trauma or event with their global meaning (Park, 2009).

The process of meaning making is the ability to make intentional efforts to confront cognitions although; this process can take place unconsciously (Park, 2009). These intentional efforts are designed to change an individual's perspectives on their situation or global meaning and consists of looking for a gentle or more thorough reason why the trauma or event happened, doling out emotions internally or with others, analyzing the trauma or event for affirmatives that can come out of it, conceptualizing the event into a broader circumstance, distinguishing self from other individuals who have worse situations, and analyzing the impact of the event over an individual's life (Park, 2009). Roe and Chopra's (2003) research study involving bimonthly assessments of individuals with mental illness resulted in a finding of there being a connection with

stress related growth and an internalized purpose and meaning. This current research study hopes to expand on how the trauma or event of mental illness can evolve into intentional efforts for meaning making in adults with a mental illness.

Additionally, the idea of intentional effort to create meaning making has been assumed to result in assimilation which is changing one's perspective of a stressor therefore adopting it as part of one's global meaning or accommodation which is shifting one's global meaning to include the stressor (Park, 2009). In this current research study, the idea of accommodation will be a focus for meaning making. Even though the process of meaning making does involve individuals' assessing the trauma or event as having affirmatives does not mean that affirmatives have actually occurred (Park, 2009). The idea of accommodation with one's meaning making due to a trauma or event leads to the notion of stress related growth. The perceptions of stress related growth can be a product of assimilation or accommodation but suggested that actual stress related growth only results from accommodation (Joseph & Linley, 2005 as cited in Park, 2009).

In summary, this research study is applying the general meaning making model to support the concept of stress related growth among adults with mental illness. Meaning making is an intentional effort although it can happen unconsciously to confront a trauma or event which is a focus in this research study and the meaning making of the event/trauma of mental illness. As a result of coping and adapting with mental illness, this research study seeks to demonstrate accommodation. This accommodation from the study participants' meaning making is thought to result in stress related growth.

Method

Research Design

The design chosen for this research study was qualitative and involved conducting semi-structured interviews. This research study asked the question that when social support occurs and individuals with mental illness learn ways to cope from those social interactions, does this influence individuals' ability to experience stress related growth? The setting for the interviews took place at a Midwestern assisted living organization that incorporates housing and other services for adults with serious and persistent mental illness. This mental health organization is also designed for community living through what is called intentional communities where individuals come together as a supportive group, share a common purpose, and work cooperatively to create a lifestyle that reflects shared values. Individuals from the assisted living and intentional communities that participated in a semi-structured interview received a \$10.00 gift card.

Sample

The sample used for this research study was seven adults that have a diagnosis of mental illness. The Midwestern assisted living and intentional community organization that was accessed for this research study required adults to be at least 18 years of age and have been diagnosed with a mental illness. Demographic information was obtained during the semi-structured interviews which included study participants' education level, age, and religiosity and/or spirituality.

Protection of Human Subjects

Written approval from the Midwestern assisted living and intentional community organization to conduct this research study was obtained by letter (Appendix B). This

research study was subjected to the approval from a research committee that was formed for the purpose of this research study. The research methodology utilized in this research study was reviewed and approval was obtained through the University of St. Thomas Institutional Review Board located in St. Paul, Minnesota. The researcher in this research study adhered to the standards in the treatment of participants according to the National Association of Social Workers' Code of Ethics.

Recruitment Process. The plan to recruit study participants involved attending two monthly tenant meetings which was held at the assisted living program at the organization. A staff member introduced the researcher at the monthly tenant meetings and the researcher explained the nature of the research study to the individuals attending the monthly tenant meetings. The researcher then asked for any questions about the research study and responded. The researcher had flyers available during the monthly tenant meetings for individuals that were interested (Appendix C). Flyers were also placed in designated places at the assisted living organization. Individuals that were interested in participating in the research study contacted a member of the assisted living staff that was indicated on the flyer. Individuals at the intentional community program were informed about the study through an agency e-mail that was disseminated by the assisted living program director. Interviews were scheduled between the researcher, staff member, and interested individual. The exclusions in this research study were individuals that required guardian signature and individuals that were not able to provide informed consent due to cognitive deficits. This research was limited to eight to ten study participants.

Measures for Confidentiality and Anonymity. Research participants'

confidentiality and anonymity were protected. Study participants that expressed interest in the research study by calling the staff member on the flyer had only their first names revealed to the researcher. The semi-structured interviews were digitally voice recorded upon consent by the research participants and demographic information collected was the study participants' education level, age, and religiosity and/or spirituality. All digital voice recorded interviews are being kept in a lock file in the researcher's home and will only be accessible to the researcher. Upon completion of this research study, all digital voice recorded interviews will be destroyed on or before May 31, 2018. The typed interview transcripts and written notes from the digital voice recorded interviews identified research participants as Study Participant 1, Study Participant 2, and so forth only. The typed interview transcripts and written notes are being kept in a lock file in the researcher's home and will only be accessible to the researcher. The typed interview transcripts and written notes will be destroyed on or before May 31, 2018. The consent forms signed by each research participant did reveal their last names and are being kept in a lock file in the researcher's home and will only be accessible to the researcher. The signed consent forms will be destroyed on or before May 31, 2018.

Protocol for Informed Consent. Research participants were provided an Informed Consent Form prior to participating in an interview (Appendix D). The Informed Consent Form outlined the protective measures for the research participants and was approved by the University of St. Thomas Institutional Review Board (IRB). Research participants were given time to read the informed consent form and to ask any questions they had related to the research. Research participants were informed in the informed consent form that they were going to be asked about their education level, age,

and religiosity and/or spirituality. Research participants were informed that they were participating in a research study that involved questions on social support, skills they have learned to cope with mental illness, and how learning these skills to cope have influenced their experience with stress related growth.

Research participants were also informed that they had the option to refuse to have their voice digitally voice recorded and their first name would not be used while being interviewed. Research participants were informed that the digital voice recorded interview was to be transcribed for purposes of analyzing the information they shared. Research participants were informed that they can decide not to answer any of the questions asked during the interview. Research participants were informed the interview was completely voluntary and they could stop at anytime during the interview. Research participants were informed that there were no repercussions for not participating. Research participants were informed that the digital voice recorded interview, transcribed interview, and written notes will be destroyed on or before May 31, 2018.

Data Collection

The instrument used to collect data was an Interview Schedule (Appendix E). The Interview Schedule consisted of four closed ended questions and 8 open-ended questions. The closed ended questions asked for the study participants' age, education level, and religiosity and/or spirituality. The closed and opened ended questions on the Interview Schedule originated from findings in the research literature in the subject areas of social support and illness, coping with illness, stress related growth and illness, and other predictors of stress related growth.

Data Analysis Plan

Seven semi-structured interviews were performed in this research study. Out of the seven semi-structured interviews, one research participant was not able to complete the semi-structured interview therefore only six of the seven semi-structured interviews were analyzed. The data collected from each digital voice recorded interview were first transcribed onto a word processing document. The transcribed semi-structured interviews were then analyzed using content analysis. Content analysis is a way to evaluate verbal, written, or visual communication (Cole, 1988 as cited in Elo & Kyngas, 2008). Content analysis involves a structure similar to coding which involves categorizing components of data into a restricted number of categories (Monette, Sullivan, & DeJong, 2008). The transcribed semi-structured interviews were first organized by open coding which involved making headings and notes while the transcripts were read (Elo & Kyngas, 2008). The transcribed semi-structured interviews were read a second time and additional headings or notes were made in order to make sure all data was accounted (Burnard 1991, 1996; Hsieh & Shannon, 2005 as cited in Elo & Kyngas, 2008). The categorizing of components into categories from the transcribed semi-structured interviews was dependent on the data that was contained in the transcribed semi-structured interviews and the meaning the data provided in responding to the research question.

Once a thorough evaluation of the transcribed semi-structured interviews for headings were completed, the data was grouped together to create themes so there was a reduction in the categories and as a result broader categories were produced (Burnard 1991; Downe-Wamboldt 1992; Dey 1993; as cited in Elo & Kyngas, 2008). This process

did include combining categories that were similar and dissimilar into the broader categories (Burnard 1991; Downe-Wamboldt 1992; Dey 1993; as cited in Elo & Kyngas, 2008). The process of categorizing was exhaustive and mutually exclusive (Monette, Sullivan, & DeJong, 2008). The themes that were created using content analysis were also then analyzed in a more abstract manner. This abstract manner involves axial coding in which the themes were related to one another in either an inductive or deductive way of analyzing the meaning of the data. Inductive is defined as focusing on specifics and then from those specifics making generalizations regarding the data (Kyngas & Vanhanen, 1999 as cited in Elo & Kyngas, 2008). Deductive is making generalizations and then focusing on specifics about the data.

Findings

The process of content analysis on the six semi-structured interviews resulted in five main themes emerging from the data (Appendix F). The themes are social support, learning from others, coping skills with feelings and stress, managing conflict and assertiveness, and people's reactions to mental illness.

Social Support

The social support theme involved a number of different sources where research participants reported obtaining social support. The first source of social support came from research participants' participation in a program. The research participants were involved in programs that either provided assisted living or intentional community living. Demographic information collected from the research participants resulted in an age range of 28-62 with the average age being 43. The education level resulted in one research participant not completing high school and the majority of the research

participants having some college or vocational training. One research participant had received a four year degree. Religious or spiritual identity resulted in one study participant identifying with Catholicism, one study participant identifying as Pagan, one research participant having past experience with the Baptist religion, one research participant's belief that 'loving people' identifies as believing in God and being spiritual, and one study participant identifying as being Agnostic unless having a manic episode would then be spiritual.

Support from program members was experienced by attending group meetings to socialize and to be a source of support to each other. Discussion in these groups involves talking about how each group member is doing mental health wise and the different things group members are doing to improve their mental health. Research participants also expressed how being a part of these groups and having mental health issues in common created unity among the group members. Group members sharing challenges about mental health issues helps group members to realize they are not the only ones, that other group members may be having the same feelings, and because they have some of the same challenges that they can heal together as a group. A finding in this research study is group unity that the research participants expressed and an example of this is when one study participant stated:

"...as far as understanding the connection that we have here with mental illness, it brings us together because we can understand, appreciate, 'I know where you are coming from and it will get better'..."

Research participants also shared that being a part of these groups involves having

meals, doing activities such as playing games or watching movies, and going out into the community together for activities together. One important aspect to these groups going out into the community is that plans for meals and other activities are done by group consensus so that they are acting as a community.

The theme of social support also involved study participants' in both the assisted living and intentional community programs discussing barriers to being fully a part of the programs that they were involved in. One barrier was the perception that some group members within a group created division among the group due to race differences. A good example of this perception in race differences being a barrier to full participation in groups was when one research participant stated:

"...some people feel like there is a little bit of racism going on in our group and it is like I can see that because I know that happens in the world so I just try to do the best I can to make that person feel comfortable and be like 'I am sorry you feel that way and that is not who I am and if I can help in any way' ..."

Research participants perceived another barrier to being a full participant in their respective programs was that other program participants were not being courteous and respectful to other program members.

A second source of social support for research participants was outside program support. Research participants described having support from friends while attending school or from past school attendance. Research participants discussed having family support that was either very supportive or that was non-existent. Research participants that did not have family support contributed this to family members not being accessible,

research participants not getting along with family members, and family members rejecting the research participants. A noteworthy perspective that was described by research participants was the reciprocation in social support being difficult because either the research participants did not perceive being able to ask for support due to family members having their own problems or family members asking the research participant for support when they were not in position to do so. A good example of the difficulty in providing reciprocation in social support is when one research participant stated regarding a brother:

“...whose door does he come knocking on, mine, and I am tired of it. I told him like I cannot do it anymore because it was starting to hurt me because I was starting to feel like I wanted to use again because he was getting to me and I had a couple of surgeries in the past year; and you know it was like, I just needed to take care of myself and that was a huge stressor. I mean that was huge.”

A third source of social support was professional support. Research participants spoke very positively and at times with expressions of gratitude for having the support from counselors, case workers, psychiatrists, and other staff. Research participants described staff as willing to listen, being open, and helpful. Research participants discussed the importance of professionals being dependable, encouraging, non-judgmental, and to explain why aspects such as behavior are important. Research participants also discussed their awareness of when professionals are perceived to be “burned out” which impacts their impressions on whether professionals will be effective with them. Research participants communicated concerns that professionals should not be perceived as just doing their jobs but actually being compassionate, listening,

empathic, and rapport building with the individuals they help. A noteworthy perspective from a research participant involved the research participant having past experience working at a hospital crisis unit and then later becoming a patient herself. From these two experiences she was able to understand that when professionals just do their job and miss the relational component, it has a great impact on working with patients in recovery.

Learning from Others

The next theme that emerged from the data was learning from others which involved the challenges research participants had with interpersonal relationships. Research participants described having difficult experiences with interpersonal relationships because of their behaviors or poor verbal communication. Research participants shared that by becoming aware of what their behaviors were and how they were communicating that they were then able to learn and do things differently. A good example of learning about how one's behavior impacts interpersonal relationships is when one research participant stated:

"I have learned a lot from friends...the people that did not like...there were a lot of people that left me because of my behaviors and stuff like that and I have learned from that and in their anger..."

The learning from others theme also included research participants' participation in groups and how they learned from other group members on different ways to promote self-care. A good example of learning from others on promoting self-care is when one research participant stated:

"...it is nice to have these people come here and realize you are not the only one;

that there are other people feeling the same way, having you know crappy days, panic attacks you know or whatever. It is just nice to know you are not the only one and to hear you know other people's ideas and what helps them and try new things."

Coping Skills

The next theme that emerged from the data was coping skills with feelings and stress which involved research participants' describing ways that helped them when they are not feeling well. Research participants discussed the importance of accepting how things are in the moment and accepting who they are. Research participants also described other ways of coping such as reading, using self-talk to promote a more tolerable perspective, and also isolating themselves in order to become grounded again. Two different examples of the ways research participants cope are when they stated:

"...I have to put myself out of my depressed moods, if I am mad, and to get out of my mad mood, what I have to do is be by myself for a couple of days. Being by myself, take a bath, call it crazy, but I have to talk to myself, rationalize with myself."

"Um...sometimes I will just like read or you know get out like go out on an outing or try to figure out why I am stressed and deal with it. You know I mean like talk to somebody...you know friends...my counselor..."

Managing Conflict and Assertiveness

The theme of managing conflict and assertiveness emerged from the data based on research participants' discussions on having conflict with others in the programs they were involved in and taking personal stands on issues that were important to them. Research participants shared one way of managing conflict was with getting the

assistance from staff to help resolve conflict. Research participants also discussed managing conflicts by talking individually with the person that they were in conflict with. Research participants discussed having challenges with tolerating other program participants' perspectives but also acknowledged learning from other program participants' points of view. Research participants also discussed how other people in their programs may be going through things that they do not know about which should be considered when in conflict with another program member. An example of awareness of other program participant struggles is when one research participant stated:

"I had an incident like I said, I knew a lady at first she was really cool when she got an apartment but all of a sudden she just changed she switched up maybe she was going through more issues than everybody else..."

Additionally, research participants talked about the idea of not blaming other participants in the program while in conflict because both involved do have mental health issues and mental illness is something that impacts them equally. An example of maintaining perspective while in conflict due to mental health issues is when a study participant stated:

"...now I know how mental illness can make you fatal and I am not pointing the finger but it is going to make me fatal if I do not watch it you know..."

Along with research participants discussing how they deal with conflict with program participants, the topic of assertiveness in which research participants described as speaking up for themselves when they perceived that the behaviors of others or the way things were being managed was something they did not agree with. An example of

this is when one research participant stated:

“...so I just really had to say no to the kitchen and make a really big stand that way it has actually helped other people here to which is good...”

Research participants also discussed that when they were assertive and spoke up about things they did not agree with that they were helping other program participants as well. An example of this is when a research participant stated:

“...yeah, and it just kept getting underneath my skin and other people were coming up to me ‘God she does not have to talk to me like that.’ And you know, there were like people, they were quiet people that did not have a voice, and she will not talk to me like that, you guys like that, or me...”

People’s Reactions to Mental Illness

The theme of people’s reactions to mental illness was also a concept that emerged from the data. Research participants particularly talked about their experiences with family in response to their mental health issues. An example of this is when a research participant stated:

“...the years between getting a lot of my solid diagnoses and when I was diagnosed with mental health issues, I was told a lot to buck up or grow up, or just deal with it, or budget better, or you are not doing enough, or you should not need that, or it is just in your head, why don’t you get a job, why don’t you just go back to school...”

Research participants described reactions from family such as mental illness not being a real illness or that it does not exist. An example of this is when a research

participant stated:

“Most of the time, I think they struggle with the mental illness diagnosis. One of my brothers thinks it is all in your head type thing and my dad is getting a little better with it because he has anxiety too. But you know, it is kinda half, half of them are kinda this is a real thing and some of them are like you are just trying not to work or live off welfare...”

In addition, research participants commented on their family not being informed about their mental health issues. Research participants also shared how they did not allow family reaction to their mental health issues to bother them. There was also the issue that people do not want to talk about mental illness and admit that it is a medical condition that people do have.

Research participants also discussed that mental illness is very common and that it can impact everybody. An example of this is when a research participant stated:

“They could be doctors and physicists, and everybody, anybody could have mental health issues. There is not really a picture of what a person with mental illness is suppose to look like because that is why I want to write ‘But You Don’t Look Mentally Ill’ because I think people have said it to me, but it has gotten much better, the stigma, but there is still a ways to go.”

The five themes that emerged from the data provided an organized and systematic way to understand what the research participants were conveying regarding social support, coping, and stress related growth among adults with mental illness. However,

the five themes that emerged from the data content analysis was also analyzed using axial coding which involved identifying relationships among the themes through inductive and deductive reasoning. The process of axial coding resulted in identification of several relationships among the themes (Appendix G). The social support theme and learning from others theme appear to have two distinct relationships. First, the social support theme involved barriers to research participants' full participation in their programs and appears to be linked to the learning from others theme because of research participants' challenges with interpersonal relationships. The relationship that is suggested here is that research participants can learn from others in improving their interpersonal relationships than study participants may perceive fewer barriers to fully participating in the programs that they are involved in. Second, the social support theme also involved barriers to research participants' full participation in their programs and appears to be linked to the learning from others theme because of inappropriate behaviors and poor verbal communication research participants had exhibited. The relationship that is suggested here is that if research participants are able to learn how to exhibit appropriate behavior and improve verbal communication that it may help program participants to fully participate in their programs.

The social support theme and managing conflict and assertiveness theme appear to have two distinct relationships. First, the social support theme involved research participants' perspectives that having mental health issues in common with other program participants created unity among the program participants and appears to be linked with the conflict and assertiveness theme of program participants' awareness that other program participants having struggles as well. The relationship that is suggested here is

that if research participants feel unified with other program participants because of having mental health issues in common then this awareness of similar struggles may reduce conflict among the program participants. Second the social support theme involved research participants' perspectives that having mental health issues in common with other program participants created unity among the participants and appears to be linked with the conflict and assertiveness theme regarding not blaming others. The relationship that is suggested here is that if research participants feel unified with other program members because of having mental health issues in common that this may lead program participants to not blame other program participants.

The social support theme involved family support either being full support or nonexistent support, appeared to be linked to the people's reactions to mental illness theme regarding family response to mental illness. The relationship that is suggested here is that depending on the support they receive from their families, either full support or nonexistent support; this is linked to the responses they receive from their families. The learning from others theme which involved undesirable behaviors or poor verbal communication by program participants appeared to be linked to the managing conflict and assertiveness theme which involved assertiveness regarding undesirable behaviors from other program participants. The relationship that is suggested here is if study participants can learn from others about behaviors or verbal communication that is not helpful, they will be able to be assertive when it comes to the undesirable behaviors or poor verbal communication that other program participants exhibit.

Discussion

The focus of this research was to learn how social support and its relationship with coping and stress related growth relate to adults with mental illness. Research participants shared receiving social support from various sources although some challenges existed in the total satisfaction of the social support they received. Research participants discussed learning from others whether it involved conflict or supportive situations such as being in a group. Research participants also shared several methods of coping due to feelings and stress including surprisingly isolating themselves for periods of time. Research participants also highlighted approaches to managing conflict and to also be assertive when appropriate. Research participants also discussed people's reactions to mental illness particularly with when it came to their families.

The findings in this research also included suggested relationships among the themes. Relationships with social support and learning from others involved challenges with interpersonal relationships and communication with other program participants. Relationships with social support and managing disagreement and assertiveness involved program participants having similar mental health issues which created unity in groups and awareness of possible challenges others may be going through. A relationship with social support and people's reactions to mental illness involved family responses to mental illness. Lastly, a relationship was suggested between learning from others and managing conflict and assertiveness regarding program participants' challenges with interpersonal relationships and learning to have assertive communication.

The literature involved studies on social support with families and having a member with mental illness. Doornbos's (1996) research finding that family members looked for social support highlights the importance of having coping skills to support individuals with mental illness. In this current research, research participants had a number of sources for social support which they found beneficial. Families that have a member with a mental illness can benefit as well from sources of social support in their relationships with a family member with mental illness. Danoff-Burg and Revenson's (2005) longitudinal study on rheumatoid arthritis patients expounded on the benefits of interpersonal relationships, which included statements of enjoyment from rheumatoid arthritis patients. Research participants in this current research discussed how receiving support that is empathic, compassionate, and among other attributes was important to them in the social support they received from the many types of professionals they worked with.

The research literature also had study findings revealing gaps in social support for adults with mental illness such as the different types of social support individuals with mental illness perceived they were receiving in the Veterans Affairs health system and the number of hospitalizations that were occurring in a mental health hospital (Kilbourne, et. al, 2007; Huang, Sousa, Tsai, and Hwang, 2007). Research participants in this current research discussed not having adequate social support from family, professionals that are "burned out," and even a desire to extend their social networks beyond the social support they were receiving in their current program and groups. The fact that the research participants in this current research were involved in programs that provided medical services for their mental health issues and still desired to extend their current social

supports is supportive of the idea that gaps in social support still do exist in providing adequate social support for adults with mental illness.

The research literature involved studies on coping skills with families and family members with an illness and how these families coped as well as the individuals themselves with illness. Schulz and Mohamed's (2004) study involved the benefits of talking about surgery after a diagnosis of cancer using indirect comparisons and social comparisons. Research participants in this current research discussed how having mental health issues and being a part of a group to talk about what is going on in their lives was helpful. Research participants in this current research also spoke about social comparisons. For example, program participants discussed that other program members may be in a more difficult place in their lives than themselves. Roberts and colleagues (2006) research on patients with prostate cancer included a finding that social support may improve mental functioning and that a lack of social support does not encourage patients to think about or process their situation. Research participants in this current research participate in programs, groups, and communicate with professionals that encourage talking about their mental health issues, which may be improving the mental functioning of these research participants. However, research participants also discussed, at times they isolate from others in order to think about stressors or emotions that they may be trying to manage which may be improving their overall mental health.

The research literature also included research on stressful events and coping strategies in regard to stress related growth. However, this is where this current research falls short because study participants did not discuss how they processed being diagnosed with a mental illness or any meaning to them in having a mental illness diagnosis. The

discussion of a mental illness diagnosis or meaning may not be necessary because a systematic review of the research literature regarding affirmative change following trauma, indicated that stress related growth was affirmatively related to acceptance, focused coping, and affirmative reinterpretation (Linley and Joseph, 2004). Research participants in this current research discussed accepting the way things were for them and also accepting who they were. In addition, research participants were involved in focused coping such as reading and limiting social contact for self-care. Interestingly, Linley and Joseph (2004) found in their systematic review that social support was commonly not related to stress related growth. However, here lies the problem that a clear relationship between social support and stress related growth is not applicable because assessment of improved relationships, which is used in plausible stress related growth outcomes, is likely to be confounded with other factors on social support.

The research literature also included research on the factors of education, age, and religiosity and/or spirituality that may implicate stress related growth. Research in the literature on education and stress related growth were mixed and had no definitive correlations (Widows et al., 2005; Katz et al., 2001; Kinsinger et al., 2006). The research participants' education level varied from the eleventh grade to an undergraduate degree. However, education and stress related growth were inconclusive in this current study as well. The research participants' ages ranged from 28-62 with the average age being 43. Research in the literature on age and stress related growth was boosted with Linley and Joseph's (2004) study that involved a systemic review on stress related growth after adversity and trauma and indicated there was no significance to age regarding stress related growth. In the current research, there were no conclusions made regarding age

and stress related growth. Research participants' religiosity and/or spirituality ranged in this current research. Research in the literature on religiosity and spirituality do implicate a relationship with stress related growth (Calhoun et al., 2000; Costa & Pakenham, 2012). In the current study, study participants expressed a range of religious and spiritual identities and interestingly went into detailed discussions regarding their religious and spiritual beliefs which may be indicative of how religion and spirituality was important to these research participants' identities and stress related growth.

Despite the fact that researchers such as Linley and Joseph in their systemic review of trauma and stress related growth found no relationship with social support, this current research is utilizing the general meaning making model which has been involved in most theories of actual stress related growth (Park, 2009). The general meaning making model starts with an event that is perceived to be a stressor (Park, 2009). Research participants in this current research all had a diagnosis of a serious and persistent mental illness which does produce stress on individuals with such a mental health condition. The next consideration in the general meaning making model is an individual's global meaning before a stressor (Park, 2009). Global meaning involves an individual's perspectives on the possibility of positive change such as their behavior matching their goals and values, spiritual and/or religious life, relationships with people, view on life, and coping ability (Park, 2009). Research participants' global meaning in this current research study before their diagnosis of a mental illness was not explored. The next consideration in the general meaning making model is due to a stressor, an individual's global values and beliefs may become inconsistent with the perceived meaning of the stressor and therefore a process of reconciliation takes place (Park, 2009).

In this current research, this is where the research participants seemed to be at in regard to the general meaning making model as evidence by the research participants' participation in emotional and cognitive methods to reconcile with the stress and emotions they experience in order to create his or her global meaning. The general meaning making model also involves intentional efforts that are designed to change an individual's perspectives on their situation and global meaning such as doling out emotions internally or with others and distinguishing self from other individuals. Research participants in this current research demonstrated this during the course of the semi-structured interviews. Further, either through assimilation or accommodation, the perception of stress related growth can be a product but actual stress related growth only results from accommodation (Joseph & Linley, 2005 as cited in Park, 2009). The research participants did demonstrate making intentional efforts to cope and therefore may have been assimilating or accommodating. Interestingly, the researcher notes that accommodation involves being intentional. The fact that the research participants in this current study are a part of an intentional living program may imply stress related growth.

These are the main themes that emerged in this research study: Receiving social support, learning from others either through conflict or receiving help from others, discussing ways that they cope due to challenging feelings and stress, approaches to managing conflict and being assertive when appropriate, and people's reactions to mental illness. From these themes, relationships were suggested such as study participants' barriers to full participation in regard to learning from others, mental health issues creating unity among group members because of sharing similar mental health issues, mental health issues detracting from conflict because of the understanding that other

group members may be having a more difficult time, mental health issues encouraging others to be assertive towards others for themselves and in turn being assertive for everybody in the program, and social support and family response to mental illness.

Implications

There are several implications from this study. Social supports are an important part in the recovery and meaning making process for individuals with mental illness. There is still a continued need to help families and the public understand mental illness and the importance of providing support to individuals with mental illness either it be from social service organizations or advocacy groups. Social workers should be encouraged that group work in helping individuals with mental illness and caregiver support groups are an important need. This research study resulted in the identification of social support, learning from others, coping with feelings and stress, and managing conflict and assertiveness as best practices when working with individuals with mental illness and the individuals that supports them. There is also a continued need to reduce the stigma that is related to mental illness by educating families and the public about mental illness being a legitimate medical diagnosis. The individuals themselves that are directly impacted by mental illness need to be provided with encouragement and welcomed as participants in society despite having a disability. There is a need for more research regarding mental illness, education level, and age and how these components relate and do not relate to stress related growth.

Strengths and Limitations

Despite the concerted effort the researcher utilized in analyzing the data using

content analysis, there were a number of limitations. One limitation was the validity of the data analysis. This is whether the categories that were created and the parts of the data that were coded were indicative of what this research proposal intended to seek (Monette, Sullivan, & DeJong, 2008). A second limitation was the small sample size that was used in this research. A larger sample could have provided a more explanatory analysis of the research question in this research study (Monette, Sullivan, & DeJong, 2008). A third limitation is the setting for this research took place at an organization providing assisted living services and intentional living programs that were designed to create socialization which may have impacted the outcomes for this research. A fourth limitation in this research is that only adults were included and it would be interesting to see how this same study would implicate the results if children and adolescents were interviewed. A fifth limitation, one that this researcher grapples with, is that most of the studies regarding stress related growth involved physical medical diagnoses that can be proved using tangible diagnostic techniques rather than the intangible diagnostic techniques for ambiguous illnesses such as mental illness. This research focused on the medical diagnosis of mental illness, which is traditionally not diagnosed the same way as other medical diagnoses, which may be indicative that researching mental illness and stress related growth needs to be researched in a separate manner than that of other medical diagnoses; but, again this underplays mental illness in our society and the stigma that is related to mental health. One other limitation to this study is that the research had a period of only 9 months in which to complete this research study.

There were strengths using a content analysis approach in this study. One strength was the data obtained had more depth and was beneficial to describing what the

focus of this research study was than other methods of research (Monette, Sullivan, & DeJong, 2008). A second strength using content analysis was reliability. This is because during the process of categorizing, word occurrence was tracked and this makes the data reliable that way (Monette, Sullivan, & DeJong, 2008).

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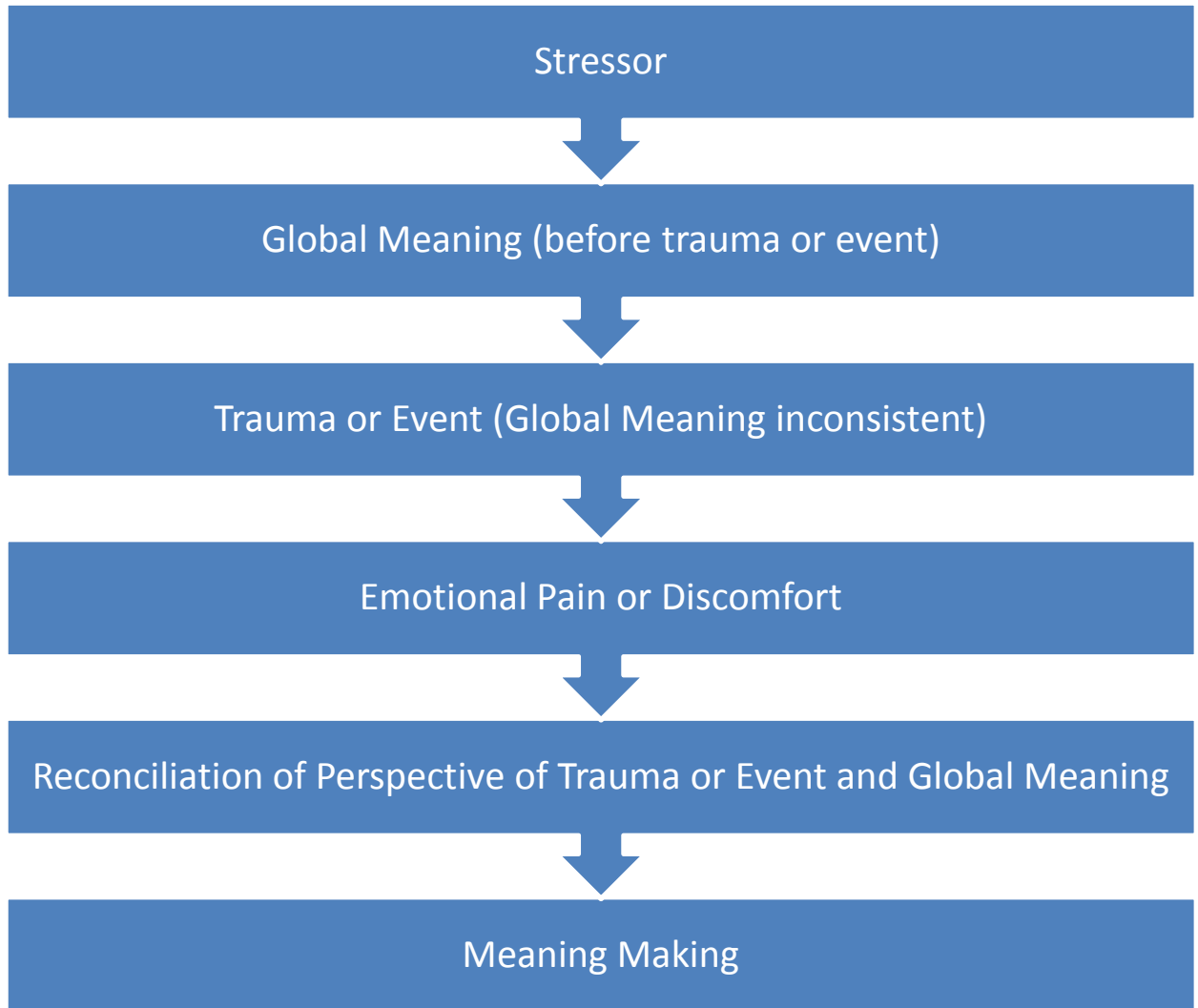
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Appendix A



Appendix B

Dear Tara Reopelle,

Thank you for reaching out to Touchstone Mental Health to conduct Clinical Research Interviews in your pursuit of coursework toward the completion of your MSW through the University of St. Thomas/ St. Catherine University.

Please accept this letter as confirmation of Touchstone Mental Health's agreement to participate in Tara Reopelle's clinical research interviews. It is understood that all information collected will be utilized for educational purposes and will otherwise be protected under the guidelines set forth through HIPPA.

If you have any questions or concerns, please contact me at 612.314.1002 or mwincell@touchstonemh.org

Sincerely,

A handwritten signature in black ink, appearing to read 'Michelle Wincell O'Leary', with a long horizontal flourish extending to the right.

Michelle Wincell O'Leary, LICSW Senior Director

Rising Cedar Apartments

Appendix C

Social Support Research

Hello, my name is Tara and I am a social work student at the University of St. Thomas. I am doing research that involves finding out more about:

- 1) the relationship between social support and the ability to cope
- 2) the relationship between social support and stress related growth

I am looking for volunteers to participate in a 30 minute interview on social support. Interviews will be digital voice recorded for research purposes. Your input will be greatly valued!! All participants that complete an interview will receive a \$10.00 Target gift card.

Interested? Please call Charles at 612-314-1001 to let him know your interest in the social support research. If Charles is not available to speak with, please either leave a message with the person who answers your call or leave a voice message. Please include a number where you can be reached at. Charles will return your call and assist in scheduling interviews. Thank you!!



Appendix D

CONSENT FORM
UNIVERSITY OF ST. THOMAS

Social Support: The Relationship with Coping and Stress Related Growth
[681614-1]

You are being asked to participate in this research because you have first-hand knowledge regarding the social support you receive and how you cope. You were recruited by either hearing the principal investigator announce the research at a monthly tenant meeting (with the availability of flyers) or by viewing a flyer in a staff approved area at your apartment building and/or community support program. You were to notify the principal investigator, Tara Reopelle, to arrange an interview. Please read this form and ask any questions you have before agreeing to participate in this research.

This research is being conducted by Tara Reopelle, principal investigator, under the guidance of Dr. Felicia Sy, PhD., LICSW at the University of St. Thomas, School of Social Work, St. Paul, Minnesota.

Background Information:

The purpose of this research is to: 1) learn how social support influences coping with illness and 2) how coping influences the ability for people to experience stress related growth. This research asks the question: What is the relationship between social support, coping with illness, and stress related growth? This research seeks to learn about the benefits of social support in relation to illness. The idea is that with social support individuals will learn from other people on ways to cope which would be helpful in managing illness. Additionally, this research seeks to discover ways coping with illness may lead to stress related growth.

Procedures:

If you agree to participate in this research, you will be involved in a 60 minute semi-structured interview. Breaks will be encouraged. The interview will be recorded using a digital voice recorder.

Risks and Benefits of Being in the Study:

The content of the interviews will not be shared with anyone at Touchstone, Mental Health Resources, Inc., any doctor, and any nurse. Your interview was arranged with Tara, the principal investigator, as indicated on the flyer, who received your first name and phone number. Please know that every effort to protect your privacy will be followed.

Though the risks to you are minimal, anytime individuals are asked to recall and reflect on their experience there is some risk of experiencing adverse reactions. Adverse reactions are unpleasant emotions and thoughts that may occur during the course of the interview. These unpleasant emotions and thoughts may have a negative impact on thinking, behavior, and mood

which may be harmful. Should you experience an adverse reaction of any kind, you are strongly encouraged to communicate this with the principal investigator. The principal investigator will then immediately inform the staff member available outside of the interview room about the adverse reaction. You will then be assisted in contacting a therapist or other appropriate person should you choose to do so.

Compensation:

You will receive a \$10.00 Target gift card upon completion of the 60 minute semi-structured interview.

Confidentiality:

In an effort to keep your participation confidential, you will be asked to complete this consent form. The information collected during the interview will be your age, education level, whether you identify as religious, and whether you identify as spiritual. The types of records created will be signed consent forms which will reveal your last name, written notes taken during the interview, transcribed interviews, and digital voice recordings from interviews and will be kept in a locked file or password protected laptop in the researcher's home and will only be accessible to the researcher. Upon completion of this research, all records, including signed consent forms, will be destroyed on or before May 31, 2018 per federal guidelines. Please know that everything that can be done to protect your confidentiality will be followed. Your identity will not be disclosed in any publication or form of information distribution that may result from the research.

Voluntary Nature of the Study:

Please keep in mind that should you agree to participate, your participation is voluntary and you can withdraw from the research at anytime without fear of retribution. You can withdraw from the research by informing the principal investigator before your interview, during the interview, and after the interview. Please note, if you do participate and decide to withdraw, you can at anytime up to and until May 1, 2015. Should you decide to withdraw, your information will not be utilized in this research. You are also free to skip any questions asked. Your decision whether or not to participate will not affect your current or future relations with Mental Health Resources, Inc., and the University of St. Thomas.

Contacts and Questions

The principal investigator's name is Tara Reopelle. You may ask Tara any questions you have now. If you have questions later, please contact Tara at 651-895-3289. You may also contact Dr. Felicia Sy, PhD., LICSW, at felicia.sy@stthomas.edu or at 612-229-3332. Additionally, you can contact the University of St. Thomas Institutional Review Board at 651-962-6038 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

I consent to having my voice digitally recorded. ☐

I do not consent to having my voice digitally recorded. ☐

Appendix E

1. What is your age?
2. How many years of school do you have?
3. Do you identify with a religion? How do you participate?
4. Do you identify with spirituality? How do you participate?

According to the National Center for Cultural Competence, Georgetown University, the word religion is “an organized system of practices and beliefs in which people engage ... a platform for the expression of spirituality...” (Mohr 2006). Spirituality is “a person’s experience of, or a belief in, a power apart from his or her own existence” (Mohr 2006).

5. How do you feel connected to people in this apartment community?
6. How do you feel connected to people outside of this apartment building?
7. How have you learned from other people on ways to deal with undesirable thinking, feeling, or behaving?
8. In what ways are you able to manage stress?
9. In what ways are you able to manage conflict?
10. In what ways do you feel you are emotionally supported by other people?
11. How has emotional support from other people helped to manage stress? Manage conflict?
12. How have connections with other people influenced you in making goals for yourself?

Appendix F

Social Support

Learning from Others

Coping with Feelings and Stress

Managing Conflict and Assertiveness

People's Reactions to Mental Illness

Appendix G

